

Accident / Incident Report Closed



Unit/Department	Process Area	Site	Report Number
South Operation-Elyria		ELYRIA	0084-SOPS-14-0010
Report Date	Incident Date	Incident Time	Copied From
01/16/2014	01/16/2014	06:00 PM	
Incident Location	Team Leader / Supervisor	Reported By	
Building 16	Raymond A Navarro	Raymond A Navarro	
Title of Event (Limit to 90 characters)	Category	Division / Bus. Group / Subgroup Code	
Nox excursion and department evacuation	<input type="checkbox"/> Safety & Health <input type="checkbox"/> Environmental	CC / G-CCP	
Incident Classification			
<input type="checkbox"/> Near Miss <input type="checkbox"/> Process Safety <input type="checkbox"/> Injury / Illness <input checked="" type="checkbox"/> Spill / Release <input type="checkbox"/> Permit / Regulatory Deviation <input type="checkbox"/> Fire <input type="checkbox"/> Odor Complaint <input type="checkbox"/> Property Loss <input type="checkbox"/> Citation / NOV <input type="checkbox"/> Health Exposure <input type="checkbox"/> Inspection <input type="checkbox"/> Major Incident <input type="checkbox"/> Non-Occupational <input type="checkbox"/> RMP <input type="checkbox"/> Contractor <input type="checkbox"/> Contractor Injury / Illness <input type="checkbox"/> Contract Injury / Illness <input type="checkbox"/> PSM <input type="checkbox"/> Plant Upset <input type="checkbox"/> EHS Management System Failure <input type="checkbox"/> Other			
Describe Event / What Happened			
<p>At roughly 6:00 pm GL Navarro was performing rounds around the department when he entered building 16 from the north end personnel door coming from outside. He immediately noticed dust / powder emanating from the discharge end of #4 RC. At that time GL Navarro called out to floor CRT and advised him of the find. At the same moment a process operator, upon hearing the conversation on the radio, came out of the MCC room adjacent to the #4RC. Process operator and GL conferred momentarily and went to get an air monitor as it appeared that it was dust coming out of the calciner discharge end. At that time there was not perceptible Nox odor which is what prompted getting the meter. Once the meter was retrieved the operator and the GL read Nox on the meter at the National dryer deck and the decision was made to evacuate the department.</p>			
Immediate Corrective Action or Response			
<p>Evacuated the entire department and activated the ERT response team. During ERT entry purge air was turned on and the manual slide gate between the #4 RC and the lab was opened some more - at that time material that seemed to have been stuck rushed through and the suction gage readout went from .5 to 1.2 which would suggest that something was plugging the line.</p>			
Immediate Cause			
<p>Purge air on the calciner was not on at the time the calciner was started - it was turned on upon entry of the first ERT Entry Team. Suction on the calciner before feeding material was at .5. Purge air read out is not available in the CRT screens on #4RC - local dial gage not working either (work notification 933870627 - emergency).</p>			
Spill Release Type(s)		Non RQ Spill / Release	
Chemical(s) Involved	CAS #	Phy. State	Air Land Water Contmt Units
Nitrogen Dioxide (NOx)	10102-44-0	Gas	6.6 0 0 0 lbs
Disposition of Material	Nox dissipated.		
Weather Conditions	Skies: Snow	Temperature: 32 F	Wind Direction: W Wind Speed:
Cause Narrative			
Material was plugged in the vent to the Trimer after maintenance shutdown and cleanout to the Trimer.			
Contributing Causes		Root/Primary Causes	
Purge air was not turned back on following maintenance on the Trimer.		208 - Personal Performance 208 - Personal Performance 208 - Personal Performance	

Blockage in exhaust line resulting in drop in suction capacity.	28 - Equipment Reliability Program Implementation LTA	32 - Preventive Maintenance LTA	34 - Scope LTA
Calcliner was shut down for maintenance prior to start-up. Start-up protocol inadequate.	192 - Communications	205 - Job Turnover LTA	207 - Communication Between Shifts LTA
Experienced calciner operator would likely have verified slide gate positioning, purge air, and feed rate prior to starting up the calciner.	163 - Training	170 - Training LTA	175 - On-the-Job Training LTA

Explanation of Root Causes

28/32/34 - Maintenance on the Trimer may have caused Trimer blockage.

192/205/207 - There was no communication on the job set-up from the previous shift prior to re-starting the calciner.

Any known or potential off-site impacts?	No	PSM Incident?	No	Estimated Cost:	5,000.00 USD
Investigation Team	Raymond A Navarro; John R Crawford; Rory O'Donnell; John Bodmann; Justin Quach; Jennifer Bailey				

Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	C: Dial gage on purge line on #4 RC needs to be replaced ASAP. It is not working. A work notification has been written - 933870627.	Gregory A Menz/BASF-CATALYSTS/BASF	01/20/2014	04/10/2014	Y	N
2	C: Need to explore the long term fisability of setting up digital read outs on the purge air controls on #4 RC and #5 RC as they are on #1, #2 and #3 calciners.	Kirk Sullenberger/BASF-CATALYSTS/BASF	03/31/2014	06/25/2014	N	N

Approved By:	
Manager / Dept. Head	Leon Zavodnik 01/30/2014 02:54 PM
EHS Unit Coordinator	Tim Anglin 02/04/2014 12:35 PM
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